433.428: continued

(c) the plan of treatment is to resume or to initiate regular weekly sessions after the resolution of the crisis.

(2) Although prior authorization is still required after 17 treatment sessions, the Division will pay a physician for more than one type of service provided to a recipient in one week if the additional service or services are medically necessary. The recipient's record must document the circumstances necessitating the provision of more than one type of service. The record must make clear that the substitution of one type of service for another would not adequately benefit the recipient and that an additional type of service is necessary.

433.429: Psychiatry Services: Scope of Services

130 CMR 433.429 describes the services that a psychiatrist may provide, including the limitations imposed on those services by the Division. For all psychotherapeutic services, the majority of time must be spent as personal interaction with the recipient; a minimal amount of time must be spent for the recording of data.

(A) Individual Psychotherapy. The Division will pay a physician for individual psychotherapy provided to a recipient only when the physician himself treats the recipient. This service includes diagnostics.

(B) Family and Couple Therapy. The Division pays for therapy provided simultaneously in the same session to more than one member of the same family or to a couple whose primary complaint is the disruption of their marriage, family, or relationship. Payment is limited to one hour per session per week, regardless of the number of family members present or the presence of a cotherapist.

(C) Group Therapy. The Division pays for therapy provided to a group of persons, most of whom are not related by blood, marriage, or legal guardianship. The Division will pay for group therapy only if the session lasts for at least 90 minutes with the physician. Payment is limited to one fee per group member with a maximum of ten members per group regardless of the presence of a cotherapist.

(D) Diagnostic Services. The Division pays for the examination and determination of a patient's physical, psychological, social, economic, educational, and vocational assets and disabilities for the purpose of designing a treatment plan. This service includes an initial medication evaluation.

(E) Reevaluation. Without prior authorization, the Division pays for the reevaluation of a recipient who has been out of treatment for at least six months and who has used up his lifetime benefit of 17 treatment sessions. A provider may bill for a maximum of two one-hour units per recipient per calendar year for the purpose of designing a treatment plan and requesting prior authorization for a particular number of sessions.

(F) Long-Term Therapy. The Division defines long-term therapy as a combination of diagnostics; individual, couple, family, and group therapy; and consultation planned to extend more than 17 sessions.

(G) Short-Term Therapy. The Division defines short-term therapy as a combination of diagnostics; individual, couple, family, and group therapy; and consultation planned to terminate within 17 sessions.

(H) Medication Review. The Division will pay for a recipient visit to the physician specifically for the prescription, review, and monitoring of medication. If this service is not combined with psychotherapy, it must be billed as a minimal office visit (Service Code 9001 or 9031). The Division will not pay separately for medication review if it is performed on the same day as another service.

433.429: continued

(I) Case Consultation. The Division will pay for a consultation with another agency or person when the physician has accepted a patient for treatment and continues to assume primary responsibility for the patient's treatment, while the other agency continues to provide ancillary services.

(J) Family Consultation. The Division will pay for a preplanned meeting of at least one-half hour with the parent or parents or legal guardian of a child who is being treated by the physician, when the parent or parents or legal guardian are not clients of the physician.

(K) Crisis Intervention/Emergency Services. The Division will pay for an immediate mental health evaluation, diagnosis, hospital prescreening, treatment, and arrangements for further care and assistance as required, provided during all hours to recipients showing sudden, incapacitating emotional stress. The Division will pay only for face-to-face contact; telephone contacts are not reimbursable. The Division will pay for no more than two hours of emergency services per recipient on a single date of service.

(L) Electroconvulsive Therapy. The Division will pay for electroconvulsive therapy only when it is provided in a hospital setting by a physician and only when both the physician and the facility meet the standards set by the Massachusetts Department of Mental Health, including those relative to informed consent.

(M) After-Hours Telephone Service. The physician must provide telephone coverage during the hours when the physician is unavailable, for recipients who are in a crisis state.

(N) Hospital Inpatient Visit. A visit to a hospitalized recipient is reimbursable only as a hospital visit (*see* 130 CMR 433.415) unless at least 15 minutes of psychotherapy is provided, in which case the service codes in Subchapter 6 of the *Physician Manual* may be used. Payment will be made for only one visit per recipient per day.

(O) Routine Inpatient Care. The Division will pay for a maximum of three weeks of routine inpatient care without prior authorization if the admission has received a preadmission screening number from the Division or its agent in accordance with 130 CMR 433.415(A). Routine inpatient care includes the following services. The amounts of services listed are the maximum reimbursable; fewer services may be provided.

(1) During the first week of hospitalization, the Division will pay for the following:
   (a) for an initial evaluation:
      1. up to three hours for a recipient under 19 years of age; and
      2. up to two hours for a recipient aged 19 or older;
   (b) for individual psychotherapy, regulation of medication, family therapy, family consultation, or case consultation:
      1. up to five hours for a recipient under 19 years of age; and
      2. up to three hours for a recipient aged 19 or older; and
   (c) for daily psychiatric-related medical care, which includes a limited examination or evaluation, treatment, and follow-up visits:
      1. up to one day for a recipient under 19 years of age; and
      2. up to three days for a recipient aged 19 or older.

(2) During each of the second and third weeks of hospitalization, the Division will pay a psychiatrist for the following:
   (a) for individual psychotherapy, regulation of medication, family therapy, family consultation, or case consultation:
      1. up to five hours for a recipient under 19 years of age; and
      2. up to three hours for a recipient aged 19 or older; and
   (b) for daily psychiatric-related medical care, which includes a limited examination or evaluation, treatment, and follow-up visits:
      1. up to two days for a recipient under 19 years of age; and
      2. up to four days for a recipient aged 19 years or older.

433.429: continued

(3) The Division will pay for only one type of service a day.
(4) In order to be reimbursable, individual psychotherapy, regulation of medication, and daily medical care must involve face-to-face contact between the psychiatrist and the recipient.
(5) For extended hospitalization, if the hospital has complied with the Division's concurrent review process, the Division will pay a psychiatrist for the services described in 130 CMR 433.429(O)(2), that is, for the same amount of services reimbursable in the second and third weeks.

433.430: Dialysis: Service Limitations

(A) Medicare Coverage. Effective July 1973, Medicare was expanded to become the primary source of payment for medical care to persons of any age who have chronic renal disease and who require hemodialysis or a kidney transplant. Recipients being treated for chronic renal disease must be referred to their Welfare Service Office or Social Security Administration office to determine Medicare eligibility.

(B) Service Limitations. Service Codes 9260, 9262, and 9264 apply only to hospitalized recipients who are:
(1) being dialyzed for acute renal failure;
(2) receiving initial dialysis for chronic renal failure prior to continuing chronic maintenance dialysis; or
(3) receiving dialysis for complications of chronic maintenance dialysis.

433.431: Physical Medicine: Service Limitations

(A) The services listed in 130 CMR 433.431 are reimbursable only when the physician prescribes the needed therapy, and the services are provided by the physician or by a licensed physical or occupational therapist employed by the physician.

(B) Physical medicine services include, but are not limited to, superficial or deep-heat modalities, therapeutic exercise, traction, hydrotherapy, prosthetics and orthotics training, activities of daily living and ambulation training, range of motion, and manual muscle strength assessment. Other restorative services are reimbursable under the Medical Assistance Program upon referral by a physician (*see* 130 CMR 433.471).

433.432: Other Medical Procedures

(A) Cardiovascular and Other Vascular Studies. Fees for cardiovascular services and other vascular studies include payment for laboratory procedures, interpretations, and physician services (except surgery and anesthesia services), unless otherwise stated. These services may be billed for in addition to an office visit.

(B) Cardiac Catheterization. Fees for cardiac catheterization are for the physician's services only and include payment for the usual preassessment of the cardiac problem and the recording of intracardiac pressure. (For consultation services, *see* Subchapter 6 of the ***Physician Manual***.)

(C) Pulmonary Procedures. Fees for the procedures listed in Subchapter 6 of the ***Physician Manual*** include payment for laboratory procedures, interpretations, and physician's services. These services may be billed for in addition to an office visit.

(D) Dermatological Special Procedures. These services may be billed for in addition to an office visit.

(E) Unlisted Procedures. Service Code 9299 should be used only if there is no "Not otherwise classified" code in the appropriate section.

433.433: Nurse Practitioner Services

130 CMR 433.433 applies specifically to nurse practitioners. In general, however, subject to the limitations of state law, the requirements elsewhere in 130 CMR 433.000 that apply to physicians also apply to nurse practitioners, such as service limitations, recordkeeping, report, and prior authorization requirements.

(A) (Reserved)

(B) Reimbursable Services. The nurse practitioner services listed in Subchapter 6 of the *Physician Manual* are reimbursable under the following conditions.

(1) The services mus: be limited to the scope of practice authorized by state law or regulation (244 CMR 4.00).

(2) The nurse practitioner must meet the educational and certification requirements mandated by state law or regulation.

(3) The nurse practitioner must enter into a formal collaborative arrangement with a physician or group of physicians as required by state law or regulation.

(C) Education and Certification Requirements. In order to participate in the Medical Assistance Program, a nurse practitioner must have successfully completed a formal educational program for nurse practitioners as required by the Massachusetts Board of Registration in Nursing.

(1) A nurse practitioner who has completed such educational requirements may provide services to recipients prior to the first certification examination for which the nurse practitioner is eligible.

(2) If the scheduled examination is missed, the nurse practitioner must immediately cease providing services to recipients.

(3) Upon receiving notice of failure to pass the examination, the nurse practitioner must immediately cease providing services to recipients.

(4) After passing the examination, the nurse practitioner must obtain authorization to practice from the Board of Registration in Nursing.

(5) When such authorization expires or is suspended, the nurse practitioner must immediately cease providing services to recipients.

(D) Collaborative Arrangement. To participate in the Medical Assistance Program, a nurse practitioner must enter into a formal collaborative arrangement with a physician or group of physicians for referral and consultation in the event of medical complications. The collaborating physician must be a Medical Assistance provider. The nurse practitioner must practice in accordance with written guidelines developed in conjunction with the physician in accordance with 244 CMR 4.22. The guidelines must specify:

(1) what services the nurse practitioner can perform; and

(2) the established procedures for common medical problems.

(E) Salaried Nurse Practitioners. When a nurse practitioner is a salaried employee of a physician or group practice, such employment shall satisfy the requirement for a collaborative arrangement.

(1) The employer must ensure that the nurse practitioner complies with the requirements in 130 CMR 433.433(C).

(2) The employer must submit claims for the services provided by the nurse practitioner. (This is an exception to 130 CMR 450.301.) Only one claim for each service may be submitted, even if a consultation is required.

(F) Independent (Nonsalaried) Nurse Practitioners.

(1) In addition to meeting the requirements of 130 CMR 433.433(C), an independent nurse practitioner must submit to the Division copies of the license issued by the Massachusetts Board of Registration in Nursing showing authorization to practice as a nurse in an expanded role, the certification by a nationally recognized accrediting body approved by the Board for nurse practitioners, and all collaborative arrangements. A nurse practitioner must notify the Division in writing within two weeks of a failure to take or pass the certification examination or of the expiration or suspension of such certification.

433.433: continued

(2) To be eligible for payment by the Division, an independent nurse practitioner must have a Medical Assistance provider number. The application for a provider number must include the name and Medicaid provider number of all collaborating physicians. Whenever the nurse practitioner enters into a collaborative arrangement with a physician other than the one indicated on the application or changes the address shown on the application, the Division must be notified in writing within two weeks after the change. Notification of a new collaborative arrangement must include the signatures of both the nurse practitioner and the new collaborating physician, as well as the new physician's Medicaid provider number.

433.436: Radiology Services: Introduction

The Division will pay for the radiology services in Subchapter 6 of the *Physician Manual* only when the services are provided at the written request of a licensed physician. All radiology equipment used in providing these services must be inspected and approved by the Massachusetts Department of Public Health.

(A) Eligible Recipients. The Division pays for the radiology services in Subchapter 6 of the *Physician Manual* when provided to Medical Assistance recipients (categories of assistance 0, 1, 2, 3, 5, 6, 7, and 8). For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 4), *see* 130 CMR 450.111.

(B) Provider Eligibility. A provider of portable X-ray services is eligible to participate in the Medical Assistance Program only if the provider is certified by Medicare.

(C) Request for Portable X-Ray Services. Portable X-ray services may be provided to a recipient at a mobile site (*see* 130 CMR 433.407(A)) at the written request of a licensed physician. This written request must specify the reason the X ray is required, the area of the body to be exposed, the number of radiographs to be obtained, the views needed, and a statement of the recipient's condition that necessitates portable X-ray services. If the recipient resides in a long-term care facility, a copy of this written request must be kept in the recipient's medical record in the facility as well as in the recipient's record maintained by the physician.

(D) Radiology Recordkeeping (Medical Records) Requirements. In addition to complying with the general recordkeeping requirements (*see* 130 CMR 433.409), the physician must keep suitable records of radiology services performed. All X-rays must be labeled adequately with the following:

(1) the recipient's name;
(2) the date of the examination;
(3) the nature of the examination; and
(4) left and right designations and patient position, if not standard.

433.437: Radiology Services: Service Limitations

See also the general limitations described at 130 CMR 433.407.

(A) Portable X-Ray Services. When a physician provides portable X-ray services to a recipient at a mobile site (*see* 130 CMR 433.407(A)), the Division will pay for the X rays according to the appropriate radiology service codes and descriptions in Subchapter 6 of the *Physician Manual*. The Division will also pay for one visit, but only one visit, regardless of the number of recipients receiving portable X-ray services at that mobile site.

433.437: continued

(B) Computerized Axial Tomography (CT Scans). CT scan services (head and body scans) are reimbursable by the Division only when performed in a facility having a Determination of Need for a CT scanner by the Massachusetts Department of Public Health. The Division will pay a physician directly only for the professional component (interpretation) of a CT scan. All CT scan services must meet current Medicare standards.

(C) Diagnostic Interpretations. When a physician provides the professional component (interpretation) of a diagnostic radiology service in a hospital inpatient or outpatient setting, the Division will pay the physician 40% of the maximum allowable fee. The Division will not pay for the interpretation of an X ray that was previously read and taken in the same hospital. However, the Division will pay a physician for interpreting an X ray that was previously read and taken in a different hospital, according to the appropriate service description in Subchapter 6 of the *Physician Manual*.

(D) Therapeutic Interpretations. When a physician provides the professional component (interpretation) of a therapeutic radiology service in a hospital inpatient or outpatient setting, the Division will pay the physician 50% of the maximum allowable fee.

(E) Surgical Introductions and Interpretations. The Division will pay a physician for performing surgical introductions and interpretations of films performed in a hospital inpatient or outpatient setting, with the following restrictions.

(1) Only one surgical introduction per operative session is reimbursable at 100% of the maximum allowable fee.

(2) In a single operative session:

(a) no more than three additional surgical introductions using the same puncture site are reimbursable, each at 50% of the maximum allowable fee; and

(b) no more than three additional selective vascular studies using the same puncture site are reimbursable, each at the maximum allowable fee.

(3) Interpretations are reimbursable at 40% of each maximum allowable fee, up to a maximum of three.

(F) Duplicate Services. Two or more identical diagnostic or therapeutic radiology services performed on one day for a recipient by one or more physicians are reimbursable only if sufficient documentation for each is shown in the recipient's medical record.

(G) Interventional Radiology. If interventional radiology services are performed by two providers, the professional component will be divided equally into surgical and interpretative components.

433.438: Clinical Laboratory Services: Introduction

Clinical laboratory services necessary for the diagnosis, treatment, and prevention of disease and for the maintenance of the health of a recipient are reimbursable under the Medical Assistance Program.

(A) Eligible Recipients. The Division pays for the clinical laboratory services in Subchapter 6 of the *Physician Manual* when provided to Medical Assistance recipients (categories of assistance 0, 1, 2, 3, 5, 6, 7, and 8). For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 4), *see* 130 CMR 450.111.

(B) Provider Eligibility. The laboratory service codes and descriptions in Subchapter 6 of the *Physician Manual* apply only to tests performed on a recipient by a physician or by an independent laboratory certified by Medicare.

433.438: continued

(C) Payment.

(1) Except for the circumstance described in 130 CMR 433.438(C)(2), the Division will pay a physician only for laboratory tests performed in his or her office. If a physician uses the services of an independent laboratory, the Division will pay only the laboratory for services provided for a recipient.

(2) A physician may bill the Division for laboratory services provided on a fee-for-service basis by the state laboratory of the Massachusetts Department of Public Health.

(D) Information with Specimen. A physician who sends a specimen to an independent laboratory participating in the Medical Assistance Program must also send the following:

(1) a signed request for the laboratory services to be performed;
(2) the recipient's Medicaid identification number; and
(3) the physician's name, address and provider number.

433.439: Clinical Laboratory Services: Service Limitations

(A) Specimen Collections. The Division will not pay a physician for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipunctures; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue). However, the Division will pay a physician who collects, centrifuges, and mails a specimen to a laboratory for analysis once per recipient specimen, regardless of the number of tests to be performed on that specimen (Service Code 108817).

(B) Professional Component of Laboratory Services. The Division will not pay a physician for the professional component of a clinical laboratory service. The Division will pay a physician for the professional component of an anatomical service (for example, bone marrow analysis or analysis of a surgical specimen).

(C) Calculations. The Division will not pay a physician for calculations such as red cell indices, A/G ratio, creatinine clearance, and those ratios calculated as part of a profile. The fees for laboratory services include payment for all aspects involved in an assay.

(D) Profile (or Panel) Tests.

(1) A profile or panel test is defined as any group of tests, whether performed manually, automatedly, or semiautomatedly, that is ordered for a specified recipient on a specified day and has at least one of the following characteristics.

(a) The group of tests is designated as a profile or panel by the physician performing the tests.

(b) The group of tests is performed by the physician at a usual and customary fee that is lower than the sum of the physician's usual and customary fees for the individual tests in that group.

(2) In no event shall a physician bill or be paid separately for each of the tests included in a profile test when a profile test has either been performed by that physician or requested by an authorized person.

433.440: Drugs: Dispensing

(A) Eligible Recipients.

(1)(a) For Medical Assistance recipients (categories of assistance 00, 01, 02, 03, 05, 06, 07, and 08), the Division pays for legend drugs as described in 130 CMR 433.440(B).

(b) For Medical Assistance recipients under age 18, the Division pays for nonlegend drugs as described in 130 CMR 433.440(B). For Medical Assistance recipients aged 18 or older, the Division pays only for nonlegend drugs that are certified to be necessary for the life and safety of the recipient. The Division will reimburse for nonlegend drugs as long as the provider's claim has attached to it a written certification on letterhead from the recipient's primary care physician that attests that such drugs are medically necessary for the life and safety of the recipient and that contains a substantiating medical explanation. However, this certification is not required for insulin, which is reimbursable provided there is a prescription for it.

433.440: continued

(2) For information on reimbursable services for recipients of the Emergency Aid to the Elderly, Disabled and Children Program (category of assistance 04), see 130 CMR 450.111.

(B) Service Limitations. The Division will pay for legend drugs that are approved by the U.S. Food and Drug Administration, except as outlined below. The Division will pay for the nonlegend drugs listed in the Nonlegend Drug List; this list is sent to pharmacies by the Division. In order to be reimbursable, legend and nonlegend drugs must be manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to Section 4401 of the Omnibus Budget Reconciliation Act of 1990. A list of the companies that have signed rebate agreements is sent to pharmacies by the Division.

(1) Interchangeable Drug Products. For drugs listed in the Massachusetts List of Interchangeable Drugs (105 CMR 720.000) or any supplement thereof, the Division will pay no more than the maximum allowable cost (MAC) or Massachusetts maximum allowable cost (MMAC) unless:

(a) the prescriber has requested and received prior authorization from the Division for a nongeneric multiple-source drug (see 130 CMR 433.408). With the prior authorization request to the Division, the prescriber must submit written supporting documentation stating the reasons the recipient's medical condition requires the nongeneric drug; or

(b) the prescriber has written on the face of the prescription in his own handwriting the words "brand name medically necessary" under the words "no substitution" in a manner consistent with applicable state law. These words must be written out in full and may not be abbreviated.

(2) Minor Tranquilizers.

(a) The Division will not pay for any drug that is classified by the Division as a minor tranquilizer, with the following exceptions:

1. generic chlordiazepoxide;
2. generic diazepam;
3. generic lorazepam;
4. generic oxazepam; and
5. generic temazepam.

The list of drugs that the Division has classified as minor tranquilizers is sent to pharmacies by the Division.

(b) The Division will pay for otherwise nonreimbursable minor tranquilizers only if the prescriber has requested and received prior authorization from the Division (see 130 CMR 433.408). With the prior authorization request to the Division, the prescriber must submit written supporting documentation of medical necessity.

(c) In an emergency where a recipient is brought to a hospital emergency room, if the prescriber wishes to prescribe an otherwise nonreimbursable minor tranquilizer for that emergency, the Division will pay a hospital pharmacy for a maximum 14-day supply without prior authorization. The Division will pay only a hospital pharmacy.

(3) Antiulcer Drugs.

(a) The Division pays for a maximum 60-day supply of antiulcer drugs per recipient per six-month period, commencing with the first prescription filled (new or refill) after December 1, 1990. The Division will pay for additional supplies of these drugs within the six-month period only if the prescriber has requested and received prior authorization from the Division (see 130 CMR 433.408). With the prior authorization request to the Division, the prescriber must submit written supporting documentation indicating that the recipient is on maintenance therapy for one of the following conditions or must submit other documentation of medical necessity:

1. duodenal or gastric ulcer;
2. Zollinger-Ellison syndrome; or
3. gastroesophageal reflux disease.

(b) Antiulcer drugs include, but are not limited to, such drugs as histamine (H_2) receptor antagonists and sucralfate.

433.440: continued

(c) Each day's supply of different antiulcer drugs prescribed for use on the same day will be counted as separate days' supplies. For example, a physician has prescribed 100 sucralfate tablets with a dosage of one tablet four times a day (a 25-day supply) and has also prescribed for the same recipient for use on the same days 50 ranitidine tablets with a dosage of one tablet twice a day (a 25-day supply). For purposes of calculating the days' supply of antiulcer drugs, the days' supply of each of the dispensed drugs is added together. Therefore, this recipient would now have used a 50-day supply of antiulcer drugs.

(4) Potassium Supplements. The Division pays for those potassium supplements listed in Appendix I of the *Pharmacy Manual*. This list is sent to pharmacies by the Division. The Division will also pay for a potassium supplement not listed in Appendix I if the prescriber has requested and received prior authorization from the Division (see 130 CMR 433.408). With the prior authorization request to the Division, the prescriber must submit written supporting documentation of the medical necessity of the drug, including the reason why none listed in Appendix I would suffice.

(5) Topical Acne Drugs. The Division does not pay for topical acne products unless the prescriber has requested and received prior authorization from the Division (see 130 CMR 433.408). The Division will grant prior authorization only for cases of severe acne. With the prior authorization request to the Division, the prescriber must submit written supporting documentation of medical necessity.

(6) Cosmetic Drugs. The Division does not pay for drugs used for cosmetic purposes or for hair growth.

(7) Nicorette. The Division does not pay for Nicorette or any other drug used for smoking cessation.

(8) Methyl Phenidate (Ritalin) and Amphetamines. The Division does not pay for methyl phenidate (Ritalin), amphetamines (including amphetamines in combination), or any other drugs when they are used for control of the appetite. When prescribed for the treatment of hyperkinesis, however, such drugs are reimbursable without prior authorization until the recipient reaches his 17th birthday. All other uses of amphetamines require prior authorization (see 130 CMR 433.408).

(9) Nonlegend Vitamins. The Division pays for nonlegend vitamins only if they are included in the Nonlegend Drug List and then only when they are dispensed to infants or children until they reach their third birthday or to pregnant women. General multiple vitamins NF (National Formulary) in a unit of 100 are reimbursable without age restriction.

(10) Vitamin B12. The Division pays for vitamin B12 only for a recipient having a diagnosis of pernicious anemia. The medical record must document the recipient's medical history as well as the physical and laboratory findings that support such a diagnosis. An office, home, or hospital outpatient visit for the sole purpose of administering vitamin B12 is reimbursable only if the B12 therapy is reimbursable.

(11) Fluorides. The Division does not pay for plain fluorides for recipients aged 12 and over unless the prescriber has requested and received prior authorization from the Division (see 130 CMR 433.408). With the prior authorization request to the Division, the prescriber must submit written supporting documentation of medical necessity.

(12) Iron. The Division pays only for those iron preparations included in the Nonlegend Drug List.

(13) Persantine. The Division does not pay for Persantine or any other dipyridamole for which the U.S. Food and Drug Administration has granted the labeling and use indication described in this subsection unless the prescriber has requested and received prior authorization from the Division (see 130 CMR 433.408). The Division will grant prior authorization only for an indication approved by the U.S. Food and Drug Administration (currently as an adjunct to coumarin anticoagulants in the prevention of postoperative thromboembolic complications of cardiac-valve replacement).

433.440: continued

(14) Less-Than-Effective Drugs. The Division does not pay for drug products (including identical, similar, or related drug products) that the U.S. Food and Drug Administration has proposed, in a notice of opportunity for hearing (NOOH), to withdraw from the market because they lack substantial evidence of effectiveness for all labeled indications. (Examples of drug products affected by 130 CMR 433.440 are listed in Appendix H of the *Physician Manual*.)

(15) Immunizing Biologicals and Tubercular Drugs.

(a) Immunizing biologicals and tubercular (TB) drugs available free of charge through local boards of public health or through the Massachusetts Department of Public Health are not reimbursable. If the recipient has a prescription, however, the Division will pay for the following drugs for a nonambulatory recipient who cannot attend one of the Department of Public Health clinics: Isoniazid, Myambutal, and P.A.S. All other such drugs require prior authorization (see 130 CMR 433.408).

(b) 130 CMR 433.440(B)(15)(a) notwithstanding, the Division does pay for pneumococcal vaccine when dispensed to a noninstitutionalized recipient.

(16) Allergy Serums. For regulations concerning payment for allergy serums, see 130 CMR 433.427.

(17) Antacids. The Division pays only for antacids dispensed to a noninstitutionalized recipient. Reimbursable antacids include those legend drugs manufactured by companies that have signed rebate agreements with the U.S. Secretary of Health and Human Services pursuant to Section 4401 of the Omnibus Budget Reconciliation Act of 1990, and only those nonlegend drugs listed in Appendix F of the *Pharmacy Manual* that are manufactured by companies that have signed rebate agreements. A list of the companies that have signed rebate agreements is sent to pharmacies by the Division. The Division pays for other antacids only if the prescriber has requested and received prior authorization from the Division (see 130 CMR 433.408). With the prior authorization request to the Division, the prescriber must submit written supporting documentation of medical necessity.

(18) Laxatives and Stool Softeners. The Division does not pay for laxatives or stool softeners unless the prescriber has requested and received prior-authorization from the Division (see 130 CMR 433.408). With the prior-authorization request to the Division, the prescriber must submit written supporting documentation of medical necessity.

(19) Cough and Cold Preparations. The Division does not pay for legend or nonlegend preparations that contain a decongestant, antitussive, or expectorant as a major ingredient, or any drug used for the symptomatic relief of coughs and colds, when they are dispensed to a noninstitutionalized recipient.

(20) Propoxyphene. The Division does not pay for any drug product that contains propoxyphene, except

(a) propoxyphene hydrochloride 32 mg; and

(b) propoxyphene hydrochloride 65 mg, unless the prescriber has requested and received prior-authorization from the Division (see 130 CMR 433.408). With the prior-authorization request to the Division, the prescriber must submit written supporting documentation of medical necessity.

(21) Hexachlorophene Preparations. The Division does not pay for preparations containing hexachlorophene, U.S.P. as the major active ingredient unless the prescriber has requested and received prior-authorization from the Division (see 130 CMR 433.408). With the prior-authorization request to the Division, the prescriber must submit written supporting documentation of medical necessity.

(22) Sex-Reassignment Hormone Therapy. The Division does not pay for drugs related to sex-reassignment surgery. This specifically includes, but is not limited to, presurgery and postsurgery hormone therapy. Notwithstanding the preceding sentence, the Division will continue to pay for post-sex-reassignment surgery hormone therapy for which it had been paying immediately prior to May 15, 1993.

(23) Unit-Dose Distribution System. The Division does not pay any additional fees for dispensing drugs in unit dose.

(24) Fertility Drugs. The Division does not pay for any drugs used to treat male or female infertility (specifically including, but not limited to, A.P.L., chorionic gonadotropins, Clomid, clomiphines, hCg, menotropins, Milphene, Pergonal, Pregnyl, Profasi, Profasi HP, and Se[illegible])

433.440: continued

(C) Payment. Drugs dispensed in the office are reimbursable at the physician's actual acquisition cost, subject to the service limitations at 130 CMR 433.404 and 433.440(B). The Division does not pay for any oral drugs dispensed in the office, with the exception of oral vaccines, for which the physician has not requested and received prior authorization from the Division. Claims for dispensing drugs must include the name of the drug or biological, the strength, and the dosage. A copy of the invoice showing the actual acquisition cost must be attached to the claim form. Claims without this information will be denied. Payment for drugs may be claimed in addition to an office visit.

433.441: Medical Supplies: Dispensing

Medical supplies dispensed in the office are reimbursable at the physician's acquisition cost if this cost is more than $1.00. Claims for dispensing medical supplies must include a complete description of the item, the quantity dispensed, and whether the item is standard or custom-made, and must have a copy of the invoice showing the acquisition cost attached to the claim form. Payment for medical supplies may be claimed in addition to an office visit.

433.451: Surgery Services: Introduction

(A) Provider Eligibility. A physician will be paid for surgery only if the physician is scrubbed and present in the operating room during the major portion of the operation. (See 130 CMR 433.421(D)(1) for the single exception to this requirement.)

(B) Reimbursable Services. All services listed in Subchapter 6 of the *Physician Manual* are reimbursable subject to Division regulations (130 CMR) and the following limitations.

(1) Any experimental, unproven, cosmetic or otherwise medically unnecessary procedure or treatment is not reimbursable. This specifically includes, but is not limited to, sex-reassignment surgery, thyroid cartilage reduction surgery, and any other related surgeries.

(2) The treatment of male or female infertility (including, but not limited to, laboratory tests, drugs, and procedures associated with such treatment) is not reimbursable.

(3) Reconstructive surgery is reimbursable only when determined by the Division pursuant to a request for prior authorization to be medically necessary to correct, repair, or ameliorate the physical effects of physical disease or defect, or traumatic injury.

(4) Abortion and sterilization procedures are reimbursable subject to specific Division regulations (*see* 130 CMR 433.455 through 433.458).

(5) Hysterectomies are reimbursable subject to specific Division regulations (*see* 130 CMR 433.459).

433.452: Surgery Services: Payment

The maximum allowable fees for the surgery services listed in Subchapter 6 of the *Physician Manual* apply to surgery procedures performed in any setting. The Division will pay a physician for either a visit or a treatment/procedure, whichever commands a higher fee; the Division will not pay for both a visit and a treatment/procedure provided to a recipient on the same day when they are performed in the same location. All maximum allowable fees for surgery procedures include payment for the initial application of casts, traction devices, or similar appliances.

(A) Obstetrics.

(1) Obstetric fees include payment for procedures performed and care given to a recipient in a hospital or at home. However, the Division will give individual consideration to a claim for extended obstetric preoperative or postoperative care due to unusual circumstances, if the physician requests it and attaches adequate medical documentation to the claim form.

(2) The Division offers the following two methods of reimbursement for obstetric services.

(a) Fee for Service. The fee-for-service method requires submission of claims for services as they are performed. Prenatal and postpartum visits are billed by using the applicable adult or pediatric office visit codes. Fee for service is always available for reimbursable obstetric services.

433.452: continued

(b) Global Fee. The global fee method offers two options, the standard global fee and the enhanced global fee (see 130 CMR 433.422 and 433.423). Both are available only when the conditions in 130 CMR 433.421 are met.

(B) Inpatient Services.

(1) For surgery procedures performed on an inpatient in a licensed hospital, the fees include payment for preoperative diagnosis and postoperative care during the period of hospitalization.

(2) The Division will give individual consideration to a claim for extended preoperative or postoperative care due to unusual circumstances, if the physician requests it and attaches adequate medical documentation to the claim form.

(3) A physician who performs an inpatient surgery procedure but does not provide the postoperative care will be paid 85% of the maximum allowable fee. The physician providing the postoperative care will be paid according to the applicable office, hospital, or home visit fee.

(C) Surgical Assistants. No payment will be made to a surgical assistant for a procedure with an allowable fee of less than $63.75. For other procedures, a surgical assistant will be paid 15% of the maximum allowable fee, with a minimum payment of $20.00.

(D) "Team" Surgery. When two or more physicians participate in an operative procedure, and when each physician contributes an expertise because of specialty training and performs a discrete portion of the operative procedure, the physician who is the consulting surgeon will be paid on an individual consideration basis. To claim payment, each consulting surgeon must indicate "team" surgery on the claim form he or she submits and must attach to it a complete operative report, including a description of each consulting surgeon's role. The physician who is the primary surgeon (surgeon of record) should bill in the usual manner.

(E) Multiple Procedures. In most circumstances, the Division will pay for only one operative procedure in a single operative session. For example, it is inappropriate to request payment for both an exploratory laparotomy and an appendectomy, or for both an arthrotomy and a meniscectomy. When two definitive procedures are performed during the same operative session, and neither procedure is designated "I.P." (for independent procedure) (*see* 130 CMR 433.452(F)), the full maximum allowable fee will be paid for one procedure, and 50% of the maximum allowable fee will be paid for each additional procedure.

(F) Independent Procedures. A number of surgery procedures are designated "I.P." in the service descriptions in Subchapter 6 of the *Physician Manual*. I.P. is an abbreviation for independent procedure. An independent procedure is reimbursable only when no other procedure is performed during the same operative session, unless one of the exceptions in 130 CMR 433.452(F)(1) through (3) applies.

(1) When during the same operative session an additional surgery procedure performed by the same physician is designated "I.P." and requires an unrelated operative incision, the full maximum allowable fee will be paid for the procedure with the largest fee, and 50% of the maximum allowable fee will be paid for each additional procedure, unless otherwise provided herein. In the event that two or more procedures are scheduled at the largest amount, the full maximum allowable fee will be paid for only one of the procedures, and 50% of the maximum allowable fee will be paid for each additional procedure, unless otherwise provided herein.

(2) When during the same operative session one or more of the surgery procedures performed by the same physician is designated "I.P." and does not require an unrelated operative incision, the maximum allowable fee will be paid for the procedure commanding the largest fee, and no payment will be made for any other procedure.

(3) When during the same operative session all of the surgery procedures performed by the same physician are designated "I.P." and one or more requires an unrelated operative incision, payment shall be determined on the basis of individual consideration.